

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/16/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G225		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/22/2011	
NAME OF PROVIDER OR SUPPLIER OCCAZIO INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE NEW CASTLE, IN47362			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0000	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 11/22/11</p> <p>Facility Number: 000749 Provider Number: 15G225 AIM Number: 100243360</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Occazio Inc. was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>This one story facility was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and common living areas. The facility has a capacity of 8 and had a census of 8 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty</p>			K0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.8.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/30/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						

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KS053	<p>Approved smoke alarms are provided in accordance with 9.6.2.10. These alarms are powered from the building electrical system and when activated, initiate an alarm that is audible in all sleeping areas. Smoke alarms are installed on all levels, including basements but excluding crawl spaces and unfinished attics. Additional smoke alarms are installed for living rooms, dens, day rooms, and similar spaces. 33.2.3.4.3.</p> <p>Exception No 1: Buildings protected throughout by an approved automatic sprinkler system, in accordance with 33.2.3.5, that uses quick response or residential sprinklers, and protected with approved smoke alarms installed in each sleeping room in accordance with 9.6.2.10, that are powered by the building electrical system.</p> <p>Exception No. 2: Where buildings are protected throughout by an approved automatic sprinkler system, in accordance with 32.3.2.5, that uses quick-response or residential sprinklers, with existing battery-powered smoke alarms in each sleeping room, and where, in the opinion of the authority having jurisdiction, the facility has demonstrated that testing, maintenance, and a battery replacement program ensure the reliability of power to smoke alarms.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 8 smoke detectors was not located where airflow could prevent the operation of the detector. LSC 9.6.2.10.1 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires,</p>			KS053	<p>Occazio, Inc. 2234 Q Ave., New Castle Survey Completed 11/22/2011 Survey Event ID DPFX21 15G225 K0053 Life Safety Code Standard The facility failed to ensure all 1 of 8 smoke detectors were installed in a location which would allow the smoke detector to function to its fullest capability. 1. What corrective action will be</p>		12/22/2011

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	<p>in spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect all clients in the facility who use the living room.</p> <p>Findings include:</p> <p>Based on observation on 11/22/11 at 11:45 a.m. with the area residential coordinator, the living room smoke detector was mounted one foot from a supply air duct. This was verified by the area residential coordinator at the time of observation.</p>				<p>accomplished? · Koorsen will relocate smoke detector in the home to a location that is at least 3 feet away from an air diffuser. 2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All clients would have the potential to be affected 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? · Residential Coordinator will monitor· Director of Residential Services will monitor· Maintenance Coordinator will monitor 4. How will the corrective action be monitored to ensure the deficient practice will not recur? · Residential Coordinator will monitor· Director of Residential Services will monitor· Maintenance Coordinator will monitor 5. What is the date by which the systemic changes will be completed? · 12/22/2011</p>		

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KS152	<p>(1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to -</p> <p>(i) Ensure that all personnel on all shifts are trained to perform assigned tasks;</p> <p>(ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.</p> <p>(2) The facility must -</p> <p>(i) Actually evacuate clients during at least one drill each year on each shift;</p> <p>(ii) Make special provisions for the evacuation of clients with physical disabilities:</p> <p>(iii) File a report and evaluation on each drill;</p> <p>(iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and</p> <p>(v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.</p> <p>(3) Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize.</p> <p>Based on record review and interview, the facility failed to conduct fire drills at least quarterly on 2 of 3 shifts during the past year. This deficient practice affects all clients in the facility.</p> <p>Findings include:</p> <p>Based on a review of the Therap Fire Drill Reports with the area residential coordinator on 11/22/11 at 11:00 a.m., there was no evidence of a first shift and</p>			KS152	<p>Occazio, Inc</p> <p>2234 Q ave. , New Castle</p> <p>15G225 Survey Event ID DPF21</p> <p>K0152 Evacuation Drills</p> <p>This standard is not met as evidenced by: Based on record review and interview, the facility failed to conduct fire drills at least quarterly on 2 of 3 shifts during the past year.</p> <p>1. What corrective action will be accomplished?</p>		12/22/2011

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	second shift fire drill for the second quarter of the year 2011. Based on an interview with the area residential coordinator on 11/22/11 at 11:10 a.m., and after a review of the past year's Therap Fire Drill Reports, there was no evidence a first shift and second shift fire drill was conducted for the second quarter of the year 2011.		<ul style="list-style-type: none"> Evacuation drills will be conducted on every shift every quarter 2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? <ul style="list-style-type: none"> All clients in the home have the potential to be effected. Each client will have a yearly assessment (Individual Plan of Protections) 3. The following measures will be put into place to ensure that the deficient practice does not recur. <ul style="list-style-type: none"> Additional staff training will be provided at the next staff meeting on documenting fire drills/ evacuation drills. An evacuation drill monitoring form will be used to assist in monitoring the drills. 4. The corrective actions will be monitored to ensure that the deficient practice does not recur in the following manner. <ul style="list-style-type: none"> RC will monitor on a monthly basis as part of their assigned duties. The ARC will monitor on a quarterly basis as part of the oversight duties. 5. The date by which the systemic changes will be completed is as follows. <ul style="list-style-type: none"> 12/22/2011 		